HARDSHIP CONSIDERATIONS

Instructions

Please read all questions carefully. All "yes" answers must include a detailed explanation and appropriate documentation (attach additional pages as needed). Return the completed form to the Community Behavioral Health Provider or mail to Community Behavioral Health within 30 days of initial ineligibility determination. Community Behavioral Health will make a determination on eligibility within 30 days of receiving the competed form and necessary verifications.

Personal Information *(Please Print)* CID #: _____

Consumer Name: _____
(First) *(MI)* *(Last)*

Address: _____ Ph. #: _____
(Street) *(City)* *(State)* *(Zip)*

Parent/Guardian or Representative (if applicable):_____

Address (if different from above): _____

☐ **YES** ☐ **NO** Are you responsible for the care of extended family members or other household members? If yes, please list whose care you are responsible for and provide documentation of expenses.

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☐ **YES** ☐ **NO** Do you have debt from prior chemical dependency treatments, illness, or other out of pocket medical expenses? For gambling services only, identify gambling losses/debt. If yes, please include bills or receipts of such debt and/or expenses.

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YES ☐ **NO** Have you had any unforeseen/uncontrollable expenses (other than medical expenses)? If yes, please give a detailed description of the expenses and provide bills/receipts.

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☐ **YES** ☐ **NO** Are there two or more persons in your household who have disabilities or are chemically dependent? If yes, please list each individual who has a disability, or is chemically dependent, and what their specific disability is. Also provide documentation of expenses that result from such disabilities or expenses that result from chemical dependency related problems/treatment.

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☐ **YES** ☐ **NO** Do you or another household member have more than one disability? If yes, please list the individual and the specific disabilities. Also provide documentation of expenses that result from such disabilities.

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☐ **YES** ☐ **NO** Do you have extraordinary housing or costs of care (e.g., paying rent during hospitalization)? If yes, please describe and provide documentation.

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☐ **YES** ☐ **NO** Do you have excessive transportation costs? If yes, please describe and provide documentation.

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☐ **YES** ☐ **NO** Do you have other expenses/circumstances that would make paying for mental health or chemical dependency services an undue financial stress (e.g., expenses incurred while gambling)? If yes, please describe and provide documentation.

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☐ **YES** ☐ **NO** Are you a person 18 years of age or older with a mental health and/or chemical dependency living with a parent or sibling because no other satisfactory living arrangement is available? If so, enter parent or siblings income below so it may be deducted from the Means 101.

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I hereby attest that this information is true and correct. I understand that any false statements that I make and any failure on my part to report change in circumstance which affect my eligibility could result in my being responsible for reimbursement of services provided and/or ineligibility for services.

_____

Signature (Consumer or Parent/Guardian) Date

Community Behavioral Health Nordstrom Building, 521 East Sioux Ave c/o 700 Governors Drive Pierre, SD 57501 (605) 773-3123 or 1-800-265-9684	**Division of Community Behavioral Health Use Only** ☐ Eligible ☐ Ineligible Date Reviewed: Signature of Reviewers: Signature of Assistant Director or Director: